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A 000	Initial Comment Original Complaint Investigation 2661616/IL200073 - 295.6000 a) 5) 13), 295.4060 c) e) f) Original Complaint Investigation 2662034/IL200280 - 295.5000 d) f) 5) j) 3) 4) 5) 295.6000 a) 5) 13) Original Complaint Investigation 2662141/IL 200324-No deficiency cited. Original Complaint Investigation 2662385/ IL200389-No deficiency cited.	A 000		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Type 1 Violation-Repeat Section 295.4060 Alzheimer's and Dementia Programs c) No persons shall be accepted for residency or remain in residence if the person's mental or physical condition has so deteriorated to render residency in such a program to be detrimental to the health, welfare or safety of the person or of other residents of the establishment. The assessment must be approved by the resident's physician and shall occur prior to acceptance for residency, annually, and at such time that a change in the resident's condition is identified by a family member, staff of the establishment, or the resident's physician. (Section 150(c) of the Act) e) No person shall be accepted for residency or	A4060		

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remain in residence if the person is dangerous to self or others and the establishment would be unable to eliminate the danger through the use of appropriate treatment modalities. (Section 150(d) of the Act)
f) No person shall be accepted for residency or remain in residence if the person meets the criteria provided in subsections (b) through (g) of Section 75 of the Act. (Section 150(e) of the Act)

Based on record review and interview the establishment failed to ensure residents (R1) are not a danger to themselves or others. This failure resulted in R2 being struck in the head approximately six times by R1. R2 sustained open head wounds which required treatment at the local emergency room. This failure creates a substantial probability of severe harm to a resident or residents.

Findings include:

R1 was admitted to the establishment's memory care unit on 01-09-2026, with physical move in date on 01-14-2026. R1's diagnoses include Lewy Body Dementia with Psychotic Disturbances.

R1's 01-14-2026 Service Plan includes documentation that R1 will receive assistance with bathing two times a week and that staff will monitor R1's skin and notify the nurse of any changes to R1's skin, such as redness, bruising, or open areas. Further documentation includes that R1 will receive assistance with dressing, grooming, toileting, and mobility. The service plan includes documentation that if R1 is resistant to care that staff are to be patient, and offer gentle cues and reassurance to promote care. R1's service plan includes documentation that R1

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is allergic to shrimp, that R1 wanders in the community, and that R1 likes to move furniture and pick up chairs. The service plan contains documentation that R1 can be easily redirected by asking R1 to help work on another project. Documentation also includes that R1 can be stubborn and refuse assistance if told what to do and that staff should "suggest that (R1) help work on a project" to redirect R1. If R1 becomes agitated that staff will ensure R1 is safe and leave R1 alone for 10-15 minutes before returning with a different approach to assist. Further documentation is that if this approach does not work that staff are to ensure R1 is safe and leave for another 10-15 minutes before returning with another staff to attempt assistance. The service plan includes documentation that R1 receives medication administration from licensed nurses.

R1's 01-14-2026 progress note contains documentation that R1 moved into the establishment today and that R1 needs assist with all activities of daily living. Documentation includes that R1 ambulates with stand by assist, likes to move furniture and tap on the walls.

R1's 01-15-2026 progress notes contain documentation that R1 is walking down hallway shirtless and staff attempted to redirect R1 to put a shirt on to eat dinner when R1 started hitting, elbowing, punching at staff. Documentation also includes that the nurse was made aware of the incident. Documentation includes that R1 was not able to be redirected and was allowed to calm down. Further documentation is that R1 was attempting to urinate in the dining room and when staff tried to redirect R1, that R1 elbowed staff in the chest. R1 was very combative, went into other resident rooms and was throwing furniture. R1 could not be redirected or calmed down and

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an ambulance was called. Documentation includes that R1's daughter was notified that R1 was sent to the local emergency room due to behaviors. R1's 01-15-2026 progress notes also include documentation that R1 was removing R1's clothes and when staff redirected R1, that R1 started swinging and punching at staff. Documentation also includes that the Director of Nurses and Family Advocate were notified. Documentation includes that R1 attempted to urinate on a dining room table and became combative with staff attempting to redirect R1. R1 then went to another resident's room and "destroyed it by throwing (resident's) furniture;" that staff intervened and R1 was combative. Documentation includes that the Executive Director was notified and unable to calm R1 down. An ambulance was called to transfer R1 to the emergency room.

R1's 01-16-2026 progress notes contain documentation that R1 returned from the emergency room at approximately 12:30am with R1's daughter, that R1 had been given medications to decrease the agitation and combative behaviors, and that R1 was calm and sleeping later. Further documentation is that R1's power of attorney and facility staff spoke together regarding the 01-15-2026 behaviors and that the Health and Wellness Director will re-educate staff on redirection techniques.

R1's 01-17-2026 progress notes include documentation of R1 picking skin on the right knee causing bleeding. Further documentation is that R1 started moving furniture and pulling on wires in the common area around 2:30pm, that R1 got very aggressive when staff tried redirecting R1 by swinging arms and hitting staff, kicking staff, spitting on staff. Documentation

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includes that R1 was redirected, given an as needed medication, and that a one to one care staff was designated to watch R1 for the rest of the day.

R1's 01-19-2026 progress note includes documentation of R1 "being very hostile and combative to staff" due to not wanting wet under clothes changed. Documentation includes that R1 was using profanity and body shaming staff and residents. Documentation also includes that R1 had to be redirected from throwing chairs at other residents several times.

R1's 01-21-2026 progress note includes documentation that R1 went into another resident's room and "totally tore it up." Further documentation is that the Director of Nurses states that "we don't know how to approach dementia patients." Documentation includes that R1 had taken a stool in the common living area and almost hit another resident with the stool when staff intervened to protect the other resident. Further documentation is that R1 began swinging at staff while trying to provide care; that R1 punched staff, was calling racist names and cursing at staff. Documentation also includes that R1 broke another resident's eyeglasses and is unable to be redirected.

R1's 01-24-2026 progress notes include documentation that R1 was combative the entire shift while being redirected from other resident rooms, and that R1 refused as needed medications to be given. Documentation includes that staff were attempting to toilet R1 and R1 became physically aggressive, striking the staff member in the breast and arm area, and that other staff were unable to redirect R1. Further documentation includes that R1 was observed in

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another female resident's room and had put on the female resident's shirt wrong, that the shirt was wound tightly around R1's chest and had to be cut with scissors to remove the shirt from R1.

R1's 01-28-2026 progress note includes documentation that R1's family states they don't want R1 to receive Olanzapine and that a request was sent in to discontinue to medication order. Further documentation is that an order to discontinue the medication was received.

R1's 02-05-2026 progress note includes documentation that R1 is being aggressive with other residents. R1 calling one resident a curse word while the resident had family visiting and then getting in between R1 and the resident to prevent R1 from hitting the other resident. Documentation includes that R1 was observed near another resident and their family visiting and the family had to intervene. R1 started swinging at staff and when staff were asked to leave R1 alone, R1 kept walking up to the other resident. R1's family was called and informed of behaviors would be awhile before they could come to facility. The Executive Director was notified of R1 being a danger to other residents and staff, and the staff were instructed to send R1 to the emergency department. Documentation includes that an ambulance was called and that R1 daughter came into the establishment. R1's daughter was informed of the ambulance being called and why and the daughter stating that R1 was not going to the emergency room. Documentation includes that R1's daughter took R1 out of the facility, and that management was notified.

R1's 02-10-2026 progress notes include documentation that R1 approached R2 during

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meal time and attempted to take R2's walker. Documentation includes that R1 "struck (R2) in head approximately six times" and that staff intervened. Documentation includes that R1 was placed with one to one staff to assist with behavior and that R1's power of attorney was notified.

R1's 02-12-2026 progress note includes documentation that R1 has not slept during the night, has been calm, that R1 has been trying to go into other resident rooms and to elope. Documentation includes that R1 was redirected several times. R1's 02-13-2026 progress note includes documentation that R1 was observed with redness to the left buttock, minor swelling to the left temporal region, and minor redness to the nose. Documentation also includes that R1 cannot state how injuries occurred and that R1's spouse said she noticed them this morning.

R1's 02-15-2026 progress notes include documentation that R1 has been very aggressive and combative towards family members and that family removed R1 and R1's belongings from the facility.

R1's 02-16-2026 progress note includes documentation that R1's power of attorney was contacted. R1's power of attorney states she believes R1 had been abused and that one of the caregivers yelled at R1's spouse. Documentation includes that the power of attorney was unable to provide more details about both situations and that an investigation into the allegations will be conducted.

R1 's 01-15-2026 Emergency Room "After Visit Summary" includes documentation that R1 was seen in the Emergency Room for aggressive

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behavior.

R1's 01-21-2026 physician order contains documentation of a "Geri Psych referral related to Dementia with agitation."

The establishment's 02-10-2026 incident contains documentation that a caregiver witnessed R1 approach R2 and attempted to take R2's walker. R2 tried to secure the walker stating that it was R2's walker. R1 struck R2 on the head with R1's hand resulting in a skin tear. Care staff intervened and notified the nurse. R1 and R2 were separated and assessed by the nurse.

The establishment's 02-16-2026 incident report contains documentation of suspected staff to resident abuse. Documentation includes that E1, Executive Director, contacted E9, Caregiver. Documentation includes that E9 states she left work early due to a report of suspected abuse and that E9 is currently suspended, pending investigation.

R2 was admitted to the establishment on 12-08-2023. R2's diagnoses include dementia, hearing impairment, and history of basal cell and squamous cell carcinoma.

R2's 02-10-2026 progress note contains documentation that during the morning meal R2 was approached by R1, and R1 attempted to take R2's walker. R1 then struck R2 in the head approximately six times, resulting in two abrasions to R1's head.

R2's 02-11-2026 progress note contains documentation that R2 returned to the establishment with family from the emergency room at approximately midnight. Further

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A4060	Continued From page 8 documentation is that R2 has steri strips in place to the head wounds. On 02-17-2026, at approximately 10:30am, E1 states that R1 was moved out of the establishment on 02-16-2026 and that R1's family moved R1 home. E1 states that she received an allegation of abuse from R1's family of staff abuse and that she sent an initial report to the Department. E1 also states that staff have been suspended pending an investigation. On 02-17-2026, at approximately 1:45pm, E1 states that R1 did not go to the Emergency Room on 01-23-2026 because R1's daughter refused for R1 to be sent out and that R1's daughter refused for R1 to be sent out to the Emergency Room on 02-05-2026. E1 states that R1's daughter refused for R1 to have a geriactric psychiatric consult and that they have electronic mail (e-mail) documentation from the daughter to facility staff regarding this. The establishment's 02-11-2026 e-mail documentation from R1's daughter to E10, (Licensed Practical Nurse, Health and Wellness Coordinator Care Concierge.) The e-mail contains documentation from R1's daughter that the referrals for geriactric psychiatric will not be necessary.	A4060		
A5000	Section 295.5000 Medication Reminders, Supervision of Self Med This Regulation is not met as evidenced by: General Violation	A5000		

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A5000	Continued From page 9 Section 295.5000 Medication Reminders, Supervision of Self-Medication, Medication Administration and Storage d) Medication administration refers to a licensed health care professional employed by an establishment engaging in administering routine insulin and vitamin B-12 injections, oral medications, topical treatments, eye and ear drops, or nitroglycerin patches. Non-licensed staff may not administer any medication. (Section 70 of the Act) f) If an establishment provides medication administration or supervision of self-administered medication, the establishment's medication policies and procedures shall be approved by a physician, pharmacist, or registered nurse and shall address: 5) Recording of medication assistance provided to residents and maintenance of medication records. j) A separate medication record shall be maintained for each resident receiving medication administration and shall include: 3) Date and time medication is scheduled to be administered; 4) Date and time of actual medication administration; and 5) Signature or initials of the employee administering medication. Based on record review and interview the establishment failed to ensure that medications administered to residents are documented per regulation. The establishment failed to ensure employees follow establishment policy and procedures when administering medications to residents. Findings include:	A5000		

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The establishment's 04/2025 Medication Administration Policy includes documentation that staff members assisting a resident with medications shall follow the procedures for administration of medications, document in the electronic Medication Administration Record, (eMAR,) immediately after administration of medication by initialing in the appropriate time slot, and maintain an accurate up-to-date eMAR.

The establishment's 04/2025 Medication Record Maintenance Policy contains documentation that an electronic medication record will be kept for each resident who receives medication administration that includes the date and time of medication administration and that name and initials of the staff who administers the medications. The policy also includes documentation that the date and time of medication administration and the staff name and intials shall be recorded at the time the medication is administered.

R1 was admitted to the establishment on 01-09-2026, with physical move in date on 01-14-2026. R1's diagnoses include Lewy Body Dementia with Psychotic Disturbances.

R1's 01-14-2026 Service Plan includes documentation that R1 receives medication administration from licensed nurses.

R1's 01-21-2026 Physician Order contains documentation for Olanzapine 5mg one tablet daily at bedtime and to change the Quetiapine 100mg to the morning instead of at bedtime.

R1's 01-28-2026 Physician Order contains documentation to discontinue the Olanzapine, monitor for increased anxiety or agitation daily for

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seven days and administer an as needed dose of Trazadone.

R1's Medication Administration Records, (MARs,) for January and February 2026 were reviewed. The January 2026 MAR does not contain documentation of Olanzapine being administered to R1. R1's February 2026 MAR does not contain documentation of R1 receiving the bedtime dosage of Quetiapine, Melatonin, or Donepezil on 02-05-2026. R1's February MAR does not contain documentation of R1 receiving the 8:00pm dosage of Quetiapine on 02-01-2026 or the 9:00am dosage of Quetiapine on 02-01-2026.

The establishment's 01-22-2026 Medication Packing Slip, contains documentation that Olanzapine 5mg, 23 tablets, for R1 was shipped to the establishment from the pharmacy.

E3's, (Health and Wellness Director,) 02-23-2026, 3:21pm, electronic mail, (e-mail,) contains documentation that R1 did receive four doses of Olanzapine 5mg. Documentation includes that the Olanzapine was ordered on 01-23-2026 and discontinued on 01-28-2026 when Z1, (R1's Power of Attorney,) requested the medication to be discontinued. Documentation includes that R1's primary care physician had decreased the Quetiapine dosages when the Olanzapine was started and that when the Olanzapine was discontinued that the Quetiapine dosages were increased.

E3's 02-24-2026, 7:57am, e-mail contains documentation that E3 pulled the delivery form for R1's Olanzapine, that the medications were shipped from the pharmacy on 01-22-2026, that E3 assumes the establishment received the medication on 01-23-2026, and that this was the

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A5000	Continued From page 12 first day R1 received the medication. Documentation also includes that on 01-28-2026 E3 had seen that four doses had been given to R1 when E3 looked at the medication in the medication cart. The same e-mail also contains documentation that when Z1 told her she did not want R1 to receive the Olanzapine that she asked E7, (Wellness Nurse,) to pull the medication from the cart and that she sent a request to R1's physician to discontinue the Olanzapine. E3's 02-24-2026, 2:16pm e-mail includes documentation that a medication error report was not completed for R1 receiving the Olanzapine and not being documented on the MAR because the nurses gave the medication based on R1 having an active prescription.	A5000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 1 Violation-Repeat Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 5) The right to receive the services specified in the service plan, to review and renegotiate the service plan at any time; and to be informed of the cost of the changes; 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor;	A6000		

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A6000	Continued From page 13 Based on record review and interview the establishment failed to ensure a resident (R2) was free from resident to resident physical abuse and failed to ensure residents received services specified in their service plans (R1-R3). This failure resulted in R2 being struck in the head approximately six times by R1. R2 sustained open head wounds which required treatment at the local emergency room. This failure creates a substantial probability of severe harm to a resident or residents. Findings include: 1.The establishment's 02-2025 Abuse, Neglect, and Financial Exploitation, Prevention, and Reporting policy was reviewed. The policy includes documentation that the establishment does not tolerate abuse, neglect and/or exploitation of residents by anyone and will do all within its powers to prevent it from occurring. R1 was admitted to the establishment on 01-09-2026, with a physical move in date of 01-14-2026. R1's diagnoses include Lewy Body Dementia with Psychotic Disturbances. R1's 01-14-2026 Service Plan includes documentation that R1 can be stubborn and refuse assistance if told what to do and that staff should "suggest that (R1) help work on a project" to redirect R1. If R1 becomes agitated, staff will ensure R1 is safe and leave R1 alone for 10-15 minutes before returning with a different approach to assist. Further documentation is that if this approach does not work staff are to ensure R1 is safe and leave for another 10-15 minutes before returning with another staff to attempt assistance.	A6000		

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	ASL510056	A. BUILDING: _____ B. WING _____	03/02/2026

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A6000	Continued From page 14	A6000		

R1's 01-15-2026 progress notes contain documentation that R1 is walking down hallway shirtless and staff attempted to redirect R1 to put a shirt on to eat dinner when R1 started hitting, elbowing, punching at staff. Documentation also includes that the nurse was made aware of the incident. Documentation includes that R1 was not able to be redirected and was allowed to calm down. Further documentation is that R1 was attempting to urinate in the dining room and when staff tried to redirect R1, R1 elbowed staff in the chest. R1 was very combative, went into other resident rooms and was throwing furniture. R1 could not be redirected or calmed down and an ambulance was called. Documentation includes R1 was sent to the local emergency room due to behaviors. R1's 01-15-2026 progress notes R1 then went to another resident's room and "destroyed it by throwing (resident's) furniture;" that staff intervened and R1 was combative. Documentation includes that the Executive Director was notified and unable to calm R1 down. An ambulance was called to transfer R1 to the emergency room.

R1's 01-19-2026 progress note includes documentation R1 had to be redirected from throwing chairs at other residents several times.

R1's 01-21-2026 progress note includes documentation that R1 went into another resident's room and "totally tore it up." Further documentation is that the Director of Nurses states that "we don't know how to approach dementia patients." Documentation includes that R1 had taken a stool in the common living area and almost hit another resident with the stool when staff intervened to protect the other resident. Further documentation is that R1 began swinging at staff while trying to provide care; that

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A6000	Continued From page 15 R1 punched staff, was calling racist names and cursing at staff. Documentation also includes that R1 broke another resident's eyeglasses and is unable to be redirected. R1's 01-24-2026 progress notes include documentation that R1 was combative the entire shift while being redirected from other resident rooms, and that R1 refused as needed medications to be given. Documentation includes that staff were attempting to toilet R1 and R1 became physically aggressive, striking the staff member in the breast and arm area, and that other staff were unable to redirect R1. R1's 02-05-2026 progress note includes documentation that R1 is being aggressive with other residents. R1's 02-10-2026 progress notes include documentation that R1 approached R2 during meal time and attempted to take R2's walker. Documentation includes that R1 "struck (R2) in head approximately six times" and that staff intervened. Documentation includes that R1 was placed with one to one staff to assist with behavior and that R1's power of attorney was notified. R2 was admitted to the establishment on 12-08-2023. R2's diagnoses include dementia and hearing impairment. R2's 02-10-2026 progress note contains documentation that during the morning meal, R2 was approached by R1. R1 attempted to take R2's walker. R1 then struck R2 in the head approximately six times, resulting in two abrasions to R1's head.	A6000		

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A6000	Continued From page 16 The establishment's 02-10-2026 incident report contains documentation that a caregiver witnessed R1 approach R2 and attempted to take R2's walker. R2 tried to secure the walker stating that it was R2's walker. R1 struck R2 on the head with R1's hand resulting in a skin tear. Care staff intervened and notified the nurse. R1 and R2 were separated and assessed by the nurse. R2's 02-11-2026 progress note contains documentation that R2 returned to the establishment with family from the emergency room at approximately midnight. Further documentation is that R2 has (adhesive strips) in place to R2's head wounds. 2. R1's was admitted to the establishment on 01-09-2026, with a physical move-in date on 01-14-2026. R1's diagnoses include Lewy Body Dementia with Psychotic Disturbances. R1's 01-14-2026 Service Plan includes documentation that R1 will receive assistance with bathing two times a week. R1's January 2026 Care Summary was reviewed and contains documentation that R1 received a shower on 01-16-2026 and 01-30-2026; the Care Summary does not contain any documentation of R1 refusing showers. R1's February 2026 Care Summary was reviewed and does not contain any documentation of receiving showers. The Care Summary does not contain any documentation of R1 refusing showers. R1's progress notes were reviewed and contain documentation of R1 being aggressive and	A6000		

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combative; however, the progress notes do not contain documentation of R1 refusing showers.

On 02-23-3036 at 12:27pm, E9, (Certified Caregiver) states that R1 was hard to re-direct and that she would mark R1 as a refusal with cares if R1 became violent.

On 02-24-2026 at 9:05am, E7, (Wellness Nurse,) states that when staff tried to provide care to R1 that R1 would become combative and that most staff would then allow R1 to refuse care.

3. R2 was admitted to the establishment on 12-08-2023. R2's diagnoses include dementia.

R2's 02-15-2026 service plan includes documentation that R2 requires assistance with bathing two times a week. The service plan also contains documentation that R2 will refuse care at times, especially with showers.

R2's Care Summary report does not contain any documentation of R2 receiving showers for January through February 18, 2026

3. R3 was admitted to the establishment on 01-19-2026. R3's diagnoses include hearing impairment and dementia.

R3's 01-22-2026 service plan includes documentation that R3 requires assistance with bathing two times a week.

R3's Care Summary report contains documentation of R3 receiving a shower on 01-13-2026 and does not contain any further documentation of showers received in January through February 18, 2026.

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A6000	Continued From page 18 On 02-24-2026, at approximately 12:06pm, E3, (Health and Wellness Director,) states that the establishment has switched over to an electronic system to document care and that it is an ongoing process to get caregivers to document care provided. E3 states that she assures all residents are getting regular care including showers, but that the documentation does not always support this. E3 states that caregivers do have the ability to chart in the charting system, that the establishment has had ongoing discussions and training on this process.	A6000		